**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

CENTER FOR PAIN MANAGEMENT
2637 CORNERSTONE BLVD
EDINBURG TX 78539

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number**
M4-11-0513-01

**MFDR Date Received**
OCTOBER 12, 2010

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "I received a denial on 6-1-10 stating morphine was allowed per invoice submitted. My invoice is reflecting a charge of $57 Dollars, maning that wwe paid more than what Texas Mutual is reimbursing us…I called Texas Mutual and as per the auditor that reviewed my bill code was paid according to the 20cc that the Dr. used, to my understanding providers should get reimbursed according to the Medicare compounded drug fee schedule."

**Amount in Dispute:** $500.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Texas Mutual made an appropriate payment amount for code J7799-KD for the following reasons: There is no maximum allowable reimbursement given by a DWC fee guideline for code J7799-KD. Absent such one must loof to Medicare given the legislative mandate to use Medicare payment weights and methodologies. The Medicare fiscal Intermediary for Texas is Trailblazer Health (Trailblazer) and it does provide reimbursement direction for the instant case…TrilBlazer states that for dosagesof Morphine 45mg or less the reimbursement is $40.00, while for dosages greater than 45mg the reimbursement is $60.00. However the requestor's assertion that '…it was underpaid per Medicare guidelines…' would appear to have some merit if it were not for the closing paragraph of Exhibit 1…states 'If the cost to the physician is significantly greater than the above reimbursement [$60.00], a valid invoice may be suppied with a redetermination request. It must indicate the physician made a good faith effort to purchase the drug at a reasonable cost.' Texas Mutual argues…If the physician has an invoice that shows a significantly lesser amount was paid for the drug than that allowed by Trailblazer then the lesser amount is the reimbursable one…Texas Mutual is of the opinion that the lesser of the invoiced amount or the Trailblazer amount is the appropriate reimbursement amount. In this case the lesser was $22.00 further reduced to $18.35."

**Response Submitted by:** Texas Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 23, 2010 | Pain Pump Refill - HCPCS Code J7799 KD | $500.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 30, 2010
   - CAC-217-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only).
   - CAC-45-Charges exceed your contracted/legislated fee arrangement.
   - 426-Reimbursed to fair and reasonable.
   - 793-Reduction due to PPO contract.

   Explanation of benefits dated May 28, 2010
   - CAC-217-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only).
   - CAC-45-Charges exceed your contracted/legislated fee arrangement.
   - 426-Reimbursed to fair and reasonable.
   - 793-Reduction due to PPO contract.
   - 891-The insurance company is reducing or denying payment after reconsideration.

**Issues**

1. Does the documentation support that the respondent notified the requestor of a contracted fee negotiation?
2. Did the requestor support position that billing is in accordance with Medicare policy?
3. Is the requestor entitled to reimbursement?

**Findings**

1. The respondent states in the position summary that "Texas Mutual is of the opinion that the lesser of the invoiced amount or the Trailblazer amount is the appropriate reimbursement amount. In this case the lesser was $22.00 further reduced to $18.35."

   28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
   (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

   (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

   A review of the submitted documentation finds that no documentation was provided to support that the respondent notified the requestor of the contracted fee negitiation in accordance with 28 Texas Administrative Code §133.4(g).

   28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

   The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable division rules and guidelines.
2. The respondent denied reimbursement for the disputed services based upon "426-Reimbursed to fair and reasonable."

HCPCS code J7799 is defined as “NOC drugs, other than inhalation drugs, administered through DME.”

Trailblazers Health Enterprises published an article titled “Part B Drugs Used in an Implantable Infusion Pump” in March 2010. This article provided coding guidelines that indicate that “…compounded drugs used in an implantable infusion pump must be billed using Not Otherwise Classified (NOC) code J7799KD, whether a single drug or a combination of drugs is administered.” A review of the submitted medical bill supports the requestor’s position that HCPCS code J7799KD was billed in accordance with Medicare policy.

3. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

   28 Texas Administrative Code §134.203 (b)(1) states “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

   28 Texas Administrative Code §134.203 (d)(1) (2)and (3) states “The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.”

   The Division finds that HCPCS code J7799KD does not have a fee listed in DMEPOS fee schedule nor a Medicaid rate.

   28 Texas Administrative Code §134.203 (f) states “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

   28 Texas Administrative Code §134.1(f) requires in pertinent part, that reimbursement shall: “(1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:

   - The requestor states in the position summary that “I received a denial on 6-1-10 stating morphine was allowed per invoice submitted. My invoice is reflecting a charge of $57 Dollars, meaning that we paid more than what Texas Mutual is reimbursing us.”
   - Per the invoice submitted the requestor paid $22.00 for the Morphine <25mg/ml, $20.00 for the compounding fee and $15.00 for the emergency production for a total of $57.00. The requestor did not clarify how they determined that $500.00 reimbursement for a $57.00 invoice would satisfy the requirements of 28 Texas Administrative Code §134.1.
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor did not submit documentation to support that reimbursement of $500.00 is fair and reasonable.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.

- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. As a result, payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that reimbursement is due. As a result, the amount ordered is $0.00.

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## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 2/7/2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.